DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice
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MEDICARE DRUG BENEFIT AND C & D DATA GROUP

TO: Office of Management and Budget

FROM: Lori Robinson, Director
Division of Plan Data

DATE: March 9, 2010

SUBJECT: Response to CMS-R-262 Comments

CMS appreciates the comments provided on the Paperwork Reduction Act (PRA) package CMS-R-262, *Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)*. Our responses to the comments submitted are below.

Formulary Comments

1. Formulary – OTC Supplemental File
Regarding the OTC file - We are requesting clarification of the following: if Step_Therapy_Total_Groups is more than one, the fields Step_Therapy_Group_Desc and Step_Therapy_Step_Value will need to represent multiple groups. It would be consistent if we can treat this scenario the same way as the formulary file where the two fields are paired up and then repeat for each group.

CMS RESPONSE: The OTC Supplemental File works the same as the Formulary File in that step therapy groupings need to be repeated for each grouping. CMS has updated the OTC Supplemental File.

Plan Benefit Package (PBP) Comments

2. PBP – Section B – 1 a (Inpatient Hospital Acute)
The PBP software now contains the question "Does cost sharing vary based on the hospital network?" We recommend this question be further developed to capture the associated cost-sharing per tier and that the data then be programmed to pull through to Section II of the Summary of Benefits. This will allow for additional cost sharing information to be shared with beneficiaries.

CMS RESPONSE: Please note that the referenced question is not new to the PBP software. Rather, the rules associated with enabling/disabling the question have been modified. CMS will investigate into the requested enhancements for the 2012 PBP

software. These enhancements are complex in nature and will require a greater level of analysis than we have time available for 2011.

3. PBP – Section B – Throughout

For the sections listed below, the statement "Indicate whether a separate office visit cost share applies for services" has additional details/questions to populate if answered yes. Please clarify what information should be populated in the new open cells regarding the minimum/maximum co-pay questions.

8A--OUTPATIENT DIAGNOSTIC PROCEDURES AND TESTS AND LAB SERVICES – BASE 3 SCREEN
8B--OUTPATIENT DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES – BASE 2 SCREEN
14C--PHYSICAL EXAMS – BASE 3 SCREEN
14D--PAP/PELVIC EXAMS – BASE 2 SCREEN
14E--PROSTATE SCREENING – BASE 3 SCREEN
14F--COLORECTAL SCREENING – BASE 4 SCREEN
14G--BONE MASS MEASUREMENT – BASE 2 SCREEN
14H--MAMMOGRAPHY – BASE 3 SCREEN
14I--DIABETES MONITORING – BASE 2 SCREEN
16B--COMPREHENSIVE DENTAL – BASE 6 SCREEN
17A--EYE EXAMS – BASE 3 SCREEN

CMS RESPONSE: If your organization charges a separate office visit cost share in addition to the cost share incurred for the given service, you must enter this separate office visit cost sharing amount in the PBP software. Minimum and maximum cost sharing variables have been added to the applicable PBP screens to standardize this data entry.

If you have any questions regarding our responses, please contact Sara Silver at Sara.Silver@cms.hhs.gov or 410-786-3330. Thank you.